# AUDIOLOGY CONSULTANTS, P.C.

2215 E. 52nd Street #2, Davenport, IA 52807
(563) 355-7712

## Initial Tinnitus Questionnaire

Patient Name: _____DOB:_____ Date:_____

Reason for today's appointment: _____

Allergies to any medications, plastics, etc.? _____

Current medications: _____

_____

### Ear Health History

Have you been exposed to loud sounds/noise? ☐Yes ☐No If yes, explain_____

Have you ever had ear surgery? ☐Yes ☐No If yes, ear? ☐Right ☐Left type?_____

Have you ever had any head/ear trauma? ☐Yes ☐No If yes,

explain_____

Have you ever taken medication that had a toxic effect on your hearing? ☐Yes ☐No If yes, type?_____

*Have you experienced any drainage from your ear(s) within the last 90 days? ☐Yes ☐No

If yes, ☐Right ☐Left ☐Both

*Do you suffer from pain or discomfort in your ear(s)? ☐Yes ☐No

If yes, ☐Right ☐Left ☐Both

Do you have temporomandibular joint (TMJ) disorder? ☐Yes ☐No

If yes, ☐Right ☐Left ☐Both

Do you have a congenital or traumatic deformity of the ear? ☐Yes ☐No

If yes, describe: _____

Do you often have significant cerumen (earwax) accumulation in your ear canal?

☐Right ☐Left ☐Both ☐Neither

*Do you suffer from acute or chronic dizziness? ☐Yes ☐No

Please list all major surgeries (Past 10 years:

_____

_____

_____

Please list any serious illnesses (Past 10 years):

_____

_____

_____

Are you diabetic? ☐Yes ☐No

Do you have high blood pressure? ☐Yes ☐No

Please return this packet to our office by _____

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Patient Name: _____DOB:_____

## Tinnitus

*Tinnitus refers to any kind of sound in your head…ringing, hissing and so on. Think only about your tinnitus in regard to the following questions……..*

How does the tinnitus sound?_____ Constant? Intermittent?

In which ear is your tinnitus? ☐Right ☐Left ☐Both ☐Head ☐Other

How long ago did you notice the tinnitus? ☐Recently ☐1-3 years ☐3-10 years ☐More than 10 years

Do you remember the onset of your tinnitus? ☐Yes ☐No

Was it a sudden or progressive onset? ☐Sudden ☐Progressive

Was it related to any other medical or environmental condition? ☐Yes ☐No

*Does your tinnitus pulse with your heartbeat? ☐Yes ☐No

*Is your tinnitus triggered by head or neck movement? ☐Yes ☐No

Is there any one in your family who has/had tinnitus? ☐Yes ☐No

Have you consulted any other professional or tried any treatment for your tinnitus? ☐Yes ☐No

If yes, explain_____

***Does your tinnitus….***

| | | | |
|---|---|---|---|
| Make it difficult to fall asleep? | always | sometimes | never |
| Make it difficult to concentrate while reading? | always | sometimes | never |
| Make it difficult to relax in a quiet room? | always | sometimes | never |
| Make it difficult to focus your attention away from your tinnitus? | always | sometimes | never |
| Cause you to feel angry? | always | sometimes | never |
| Cause you to feel stressed? | always | sometimes | never |
| Cause you to feel sad? | always | sometimes | never |

**Office Use Only (2)___ (1)___ (0)___ Total_____**

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Patient Name: _____DOB:_____

## Sound Tolerance

*Sound tolerance refers to how you react to sounds in your environment. Think only about your sound tolerance in regard to the following questions…..*

Do you use ear protection (earplugs or earmuffs) specifically for tinnitus? ☐Yes ☐No

Do you have a decreased tolerance to sound (are sounds bothersome to you when they seem normal to other people around you)? ☐Yes ☐No

***Does sound in your environment….***

| | | | |
|---|---|---|---|
| Cause an increase in your tinnitus? | always | sometimes | never |
| Cause you to avoid going certain places? | always | sometimes | never |
| Cause you to feel irritated? | always | sometimes | never |

## Hearing

*Hearing refers to your ability to detect sounds in your environment or your ability to understand the speech of other. Think only about your hearing in regard to the following questions…*

When was your last hearing exam? _____ By whom? _____

What were the results? _____Recommendations?_____

Have you ever worn hearing aids? ☐Yes ☐No

*Have you experienced a sudden hearing loss? ☐Yes ☐No

***Does your hearing….***

| | | | |
|---|---|---|---|
| Limit or hamper your personal or social life? | always | sometimes | never |
| Cause you to hear people but not understand what they are saying? | always | sometimes | never |

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Patient Name: _____DOB:_____

**What do you consider is your main problem? Hearing ☐ Tinnitus ☐ Sound tolerance ☐**

If you answered ***"tinnitus" as your main problem…***

What percent of the time are you aware of it? _____

How *strong*, or *loud* was your tinnitus, on average, over the last month? "0" would be "no tinnitus and "10" would be "as loud as you can imagine."

0 1 2 3 4 5 6 7 8 9 10

How much has tinnitus *annoyed* you, on average, over the last month" "0" would be "not annoying at all" and "10" would be "as annoying as you could imagine."

0 1 2 3 4 5 6 7 8 9 10

How much did tinnitus impact your life, over the last month? "0" would be "not at all"; "10" would be "as much as you could imagine."

0 1 2 3 4 5 6 7 8 9 10

Have you experienced any stressful events within the last 12 months?

_____

_____

_____

How do you feel about your tinnitus?

_____

_____

_____

_____

_____

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## TH Inventory (Newman et al)

Instructions: The purpose of the questionnaire is to identify difficulties that you may experience because of your tinnitus. Please answer YES, SOMETIMES or NO, to each question. Please DO NOT SKIP Any Questions.

**Patient Name**_____ **DOB**_____ **Date**_____

| | | | | |
|---|---|---|---|---|
| F-1 | Because of your tinnitus, is it difficult for you to concentrate? | Yes | Sometimes | No |
| F-2 | Does the loudness of your tinnitus make it difficult for you to hear people? | Yes | Sometimes | No |
| E-3 | Does your tinnitus make you angry? | Yes | Sometimes | No |
| F-4 | Does your tinnitus make you feel confused? | Yes | Sometimes | No |
| C-5 | Because of your tinnitus, do you feel desperate? | Yes | Sometimes | No |
| E-6 | Do you complain a great deal about your tinnitus? | Yes | Sometimes | No |
| F-7 | Because of your tinnitus do you have trouble falling to sleep at night? | Yes | Sometimes | No |
| C-8 | Do you feel as though you cannot escape your tinnitus? | Yes | Sometimes | No |
| F-9 | Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner, to the movies, etc. …)? | Yes | Sometimes | No |
| E-10 | Because of your tinnitus, do you feel frustrated? | Yes | Sometimes | No |
| C-11 | Because of your tinnitus, do you feel that you have a terrible disease? | Yes | Sometimes | No |
| F-12 | Does your tinnitus make it difficult for you to enjoy life? | Yes | Sometimes | No |
| F-13 | Does your tinnitus interfere with your job or household responsibilities? | Yes | Sometimes | No |
| E-14 | Because of your tinnitus do you find that you are often irritable? | Yes | Sometimes | No |
| F-15 | Because of your tinnitus, is it difficult for you to read? | Yes | Sometimes | No |
| E-16 | Does your tinnitus make you upset? | Yes | Sometimes | No |
| E-17 | Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and friends? | Yes | Sometimes | No |
| F-18 | Do you find it difficult to focus your attention away from your tinnitus and on other things? | Yes | Sometimes | No |

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| | | | | |
|---|---|---|---|---|
| C-19 | Do you feel that you have no control over your tinnitus? | Yes | Sometimes | No |
| F-20 | Because of your tinnitus, do you often feel tired? | Yes | Sometimes | No |
| E-21 | Because of your tinnitus, do you often feel depressed? | Yes | Sometimes | No |
| E-22 | Does your tinnitus make you feel anxious? | Yes | Sometimes | No |
| C-23 | Do you feel that you can no longer cope with your tinnitus? | Yes | Sometimes | No |
| F-24 | Does your tinnitus get worse when you are under stress? | Yes | Sometimes | No |
| E-25 | Does your tinnitus make you feel insecure? | Yes | Sometimes | No |

F_____ C_____ E_____ T_____

Patient Name: _____ DOB:_____ Date_____

## Bauman Tinnitus Concern Questionnaire

Please rank the following from 1 to 10 in the order of concern regarding your tinnitus with 1 being the **MOST CONCERNED** and 10 being the **LEAST CONCERNED.**

_____ I am concerned about my tinnitus because it robbed me of my quietness.

_____ I am concerned about my tinnitus because it interferes with my hearing.

_____ I am concerned about my tinnitus because I am afraid it will cause damage to my hearing.

_____ I am concerned about my tinnitus because I do not know what it causing it.

_____ I am concerned about my tinnitus because I am afraid it will lead to other medical problems.

_____ I am concerned about my tinnitus because I have no control over its presence.

_____ I am concerned about my tinnitus because it interferes with my life.

_____I am concerned about my tinnitus because it interferes with my sleep.

_____ I am concerned about my tinnitus because it interferes with my concentration.

_____I am concerned about my tinnitus because it makes me tired.

If you have other concerns regarding your tinnitus, please describe.

_____

_____

_____

_____